Electronically Delivered

October 1, 2025

Licensee
Cherrywood Andover
1889 139th Avenue Northwest
Andover, MN 55304

RE: Project Number(s) SL29743016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 14, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29743	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD ANDOVER	1889 139TH AVENUE NW ANDOVER, MN 55304

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29743016-0 On August 11, 2025, through August 14, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 14 residents;14 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 11, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-D).	0 650		

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0 650	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 11, 2025, at 11:09 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee record. ULP-D was hired on June 15, 2024, to provide direct assisted living services to residents at the facility. On August 11, 2025, at 7:11 a.m., the surveyor observed ULP-D provide scheduled morning medication to R2. ULP-D's employee record lacked the following trainings and/or competency evaluations: -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; -standby assistance techniques and how to perform them; -safe transfer techniques and ambulation; and -range of motioning and position. ULP-D's employee record also lacked	0 650		

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0 650	Continued From page 5 documentation of annual performance review. On August 13, 2025, at 7:20 a.m., ULP-D stated ULP-D completed all trainings and competency testing for medications, cares, and treatments by the licensee's previous RN upon hire and prior to working with residents. On August 13, 2025, at 12:03 p.m., LALD-A stated the licensee used the wrong checklist to complete ULP-D's competencies which resulted in ULP-D not completing all required competencies. LALD-A further stated ULP-D's annual review was late related to staff turnover. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated a copy of all education, training, and competency testing shall be kept in each employee's personnel file. The licensee's Employee Evaluation policy dated August 1, 2021, indicated all staff of [licensee] will be given an employee evaluation at least annually. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency	0 650		

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0 650	Continued From page 6 evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680		

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0 680	Continued From page 7 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 11, 2025, at 10:43 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP, dated April 1, 2025, lacked evidence that the licensee conducted exercises to test the EPP at least twice per year.	0 680		

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0 680	Continued From page 8 On August 11, 2025, at 3:51 p.m., LALD-C acknowledged that the drills had not been completed in the correct timeframe. LALD-C further stated, "these drills will get back on track, no problem. I can handle this tag." The licensee's 9.01 Emergency Preparedness Plan- Appendix Z Compliance policy dated August, 1, 2021, indicated [licensee] will conduct, at minimum, two emergency preparedness drills every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	0 775		

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0 775	Continued From page 9 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 12, 2025, from 10:00 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-C and housing manager (HM)-F. The surveyor made the following observations: The fire rated door between the great room and the resident hallway, adjacent to the fire alarm control panel (FACP) room, did not close and latch. Fire resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency. These deficient conditions were visually verified at the time of discovery by LALD-C and HM-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 10 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 11 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 12, 2025, licensed assisted living director (LALD)-C and house manager (HM)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, 9.06 Fire Policy, dated August 1, 2021, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On August 12, 2025, at 1:30 p.m., LALD-C stated	0 810		

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0 810	Continued From page 12 they were developing their FSEP since being surveyed at a different location and receiving the same feedback. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of	01440		

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	29743	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD ANDOVER	1889 139TH AVENUE NW ANDOVER, MN 55304

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01440	Continued From page 13 staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for two of two unlicensed personnel [(ULP)-D and ULP-E]. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on June 15, 2024, to provide direct care services to residents of the licensee. ULP-D's employee record lacked documentation of a supervision of performing delegated tasks within 30 calendar days. ULP-E ULP-E was hired on June 26, 2025, to provide direct care services to residents of the licensee. ULP-E's employee record lacked documentation of a supervision of performing delegated tasks within 30 calendar days. On August 13, 2025, at 1:08 p.m., licensed assisted living director (LALD)-C indicated via email the licensee had "started to roll out a new 30-day supervisory visit form throughout the company as we thought the check off and the	01440		

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01440	Continued From page 14 visit could be the same thing. We do not have a separate 30-day supervisory visit for most employees at this time." The licensee's 6.17 Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on	01540		

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01540	Continued From page 15 topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP)-D received the required amount of dementia care training in the required time frame. Additionally, the licensee failed to ensure three of three employees (ULP-D, ULP-E, and ULP-G) received the required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care (ALFDC) license effective November 1, 2024. During the entrance conference on August 11, 2025, at 11:09 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record.	01540		

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01540	Continued From page 16 ULP-D ULP-D was hired on June 15, 2024, to provide direct care services to residents at the facility. On August 13, 2025, at 7:11 a.m., the surveyor observed ULP-D administer scheduled medications to R2. On August 13, 2025, at 1:08 p.m., via email, LALD-C indicated ULP-D was hired as a full-time employee who worked 72-hours per pay period. At 2:57 p.m., LALD-C clarified a pay period consists of 14-day calendar days. ULP-D's Educare (online education software) transcript indicated ULP-D completed 7.25 hours of dementia related education as of July 10, 2024, indicating 26 days had passed since ULP-D's date of hire. ULP-E ULP-E was hired on June 26, 2025, to provide direct care services to residents at the facility. On August 12, 2025, at 8:37 a.m., the surveyor observed ULP-E assist R3 with scheduled colostomy cares. ULP-G ULP-G was hired on March 31, 2025, to provide direct care services to residents at the facility. ULP-D, ULP-E, and ULP-G's employee records lacked evidence of which ULP-D, ULP-E, and ULP-G had completed training on mental illness or de-escalation by July 1, 2025. On August 13, 2025, at 1:08 p.m., LALD-C indicated via email, "As we were unaware of the	01540		

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01540	Continued From page 17 required onboarding training required, our next installment of courses will not only include Mental Illness - Response Strategies (1.0) as originally planned but also Mental Illness 1 - Overview and Depression, Mental Illness 2 - Bipolar, Anxiety, Psychosis and Trauma-Induced Disorders, and Mental Illness 3 - Personality Disorders, Substance Abuse and De-escalation to assure all employees are caught up to requirements ASAP (as soon as possible)." LALD-C further indicated ULP-D lacked additional onboarding dementia training to meet the statute requirement. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care employees would complete eight (8) hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective	01620		

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01620	Continued From page 18 resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 19 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an admission assessment and a reassessment within 14-days following admission date for two of two residents (R2 and R3), and ongoing nursing assessments not to exceed every 90-days thereafter for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee and began receiving assisted living services on February 4, 2025. R2's record included an admission assessment dated February 4, 2025, and a 14-day assessment dated on February 25, 2025, indicating 21 days had passed. R2's record also included a 90-day assessment dated on July 30, 2025, indicating 155 days had passed between assessments. R3 R3 was admitted to the licensee and began receiving assisted living services on July 11, 2025.	01620		

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01620	Continued From page 20 R3's record included an admission assessment dated July 11, 2025, and a 14-day assessment dated August 1, 2025, indicating 21 days had passed. On August 13, 2025, at 8:40 a.m., clinical nurse supervisor (CNS)-B stated "four or five" residents had assessments that were due while CNS-B was on vacation and the assessments had not been completed on time. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring would be conducted no more than 14 calendar days after initiation of services. The policy further indicated that ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the resident and would not exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880		

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01880	Continued From page 21 review, the licensee failed to ensure one of two refrigerators storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. In addition, the licensee failed to ensure medications were stored according to manufacturer's instructions in two of two medication refrigerators (140-MF and 150-MF). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 11, 2025, at 10:58 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On August 12, 2025, at 3:22 p.m., CNS-B stated the current temperature of the 150-MF was 44 degrees Fahrenheit (F). The medication refrigerator contained two boxes of house supply bisacodyl 10 milligram (mg) suppositories, one box opened, and one box remained sealed. In addition, the medication refrigerator contained three bisacodyl 10 mg suppositories prescribed to R5. The licensee's August 2025 Medication Fridge dated August 1, 2025, through August 30, 2025,	01880		

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01880	Continued From page 22 indicated the 150-MF temperature was checked every night. The August 2025 Medication Fridge indicated 12 out of 12 opportunities the medication refrigerator temperature was not recorded. On August 12, 2025, at 3:40 p.m., registered nurse (RN)-H stated the current temperature of the 140-MF was 40 degrees F. The medication refrigerator contained two boxes of house supply bisacodyl 10 mg suppositories, one box opened, and one box remained sealed. In addition, the medication refrigerator contained five acetaminophen 650 mg suppositories prescribed to R4. The licensee's August 2025 140 Medication Fridge dated August 1, 2025, through August 30, 2025, indicated the 140-MF was checked every night. The August 2025 140 Medication Fridge indicated on August 1, 2025, the medication refrigerator temperature was recorded as 35 degrees F. The same document also indicated 11 out of 12 opportunities the medication refrigerator temperature was recorded between 36- and 46-degrees F. On August 12, 2025, at 3:47 p.m., CNS-B stated medication refrigerator temperature readings were assigned to the night shift nurse daily. CNS-B further stated the temperature readings that were missed or out of range were due to staff error. The manufacturer's instructions for bisacodyl suppository 10 mg dated March 24, 2025, indicated to store suppositories at room temperature, between 59 degrees F and 86 degrees F.	01880		

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01880	Continued From page 23 The manufacturer's instructions for acetaminophen suppository 650 mg dated February 2025, indicated to store suppositories between 68 degrees F and 77 degrees F. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications managed by [licensee] were to be stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with a hospital bed rail. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	02310		

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02310	Continued From page 24 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 11, 2025, at 10:43 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included diabetes, hypertension (high blood pressure), and osteoarthritis (breakdown of cartilage that cushions the ends of bones). R2's Service Plan dated February 4, 2025, indicated R2's services included dressing, bathing and grooming, toileting, stand by assistance with transfers, medication management, glucose monitoring, housekeeping, laundry and monitoring vital signs. R2's Side Rail Assessment dated July 30, 2025, indicated R2 had 'bilateral half side rail' installed on R2's bed and R2 used the side rails for assistance getting in and out of bed and for assistance with bed mobility. The assessment further indicated that risks versus benefits were reviewed, and the surveyor confirmed R2's side rails were securely installed on the hospital style bed. R2's Side Rail Assessment lacked measurements for bedrail zones of entrapment. On August 13, 2025, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled morning medication.	02310		

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02310	Continued From page 25 On August 12, 2025, at 10:54 a.m., clinical nurse supervisor (CNS)-B stated registered nurses (RN) were trained to complete zone measurements as part of the bed rail assessment upon installation and every 90 days. CNS-B further stated the zone measurements were missed for R2 and were going to be corrected immediately by CNS-B. The licensee's 6.28 Side Rails policy dated August 1, 2021, indicated a RN would assess the bed rails to ensure the design was consistent with the Food and Drug Administration (FDA)'s 2006 recommended dimensional measurements that reduced entrapment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

CHERRYWOOD ANDOVER
1889 139TH AVENUE NW
Andover, MN 55304
Anoka County
Parcel:

Phone:

License Info

License: HFID 29743

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1029251097
Inspection Type: Full - Single
Date: 8/11/2025 Time: 1:30:27 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery:

New Order: 2-100 Supervision
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033D Post the certified food protection manager certificate.
COMMENT: PHOTOCOPY OF CFPM CERTIFICATE POSTED. POST ORIGINAL OR OFFICIAL DUPLICATE. NOTWITHSTANDING MINNESOTA RULES, PART 4626.0033, ITEM A, THE FACILITY MAY SHARE CFPM WITH ONE OTHER FACILITY LOCATED WITHIN A 60-MILE RADIUS AND UNDER COMMON MANAGEMENT PROVIDED THE CFPM IS PRESENT AT EACH FACILITY FREQUENTLY ENOUGH TO EFFECTIVELY ADMINISTER, MANAGE, AND SUPERVISE EACH FACILITY'S FOOD SERVICE OPERATION.

Comply By: 8/11/2025 Originally Issued On: 8/11/2025

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG. NAVIGATED TO WEBSITE DURING INSPECTION AND PRINTED ILLNESS LOG. ILLNESS LOGGING, REPORTING, AND EXCLUSION REQUIREMENTS REVIEWED.
Comply By: 8/11/2025 Originally Issued On: 8/11/2025

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: RAW SHELL EGGS ABOVE READY TO EAT ITEMS IN 150 2ND COOLER. CORRECTED DURING INSPECTION. ENSURE RAW ANIMAL FOODS ARE NOT STORED ABOVE RTE ITEMS. INCORRECT FOOD STACKING APPEARED TO BE AN ANOMALY AS ALL OTHER EGGS WERE STORED IN THE LOWEST CABINET IN BOTH SECONDARY COOLERS, AS IS THE FACILITY'S ESTABLISHED PROCEDURE.
Comply By: 8/11/2025 Originally Issued On: 8/11/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: WET WIPING CLOTH NOT IN USE ON SINK. KEEP WIPING CLOTHS IN SANITIZER SOLUTION WHEN NOT IN USE.
Comply By: 8/11/2025 Originally Issued On: 8/11/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: MAIN COOLER IN 150 KITCHEN NOT HOLDING AT SAFE TEMPERATURES. TEMPERATURE ABUSED TCS FOODS DISCARDED BY STAFF. VERIFY SAFE COLD HOLDING TEMPERATURES PRIOR TO PLACING ADDITIONAL TCS ITEMS INTO COOLER.
Comply By: 8/11/2025 Originally Issued On: 8/11/2025

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: CONTAINER WITH SLICED TURKEY AND SLICED HAM COMBINED BEYOND SAME-DAY SERVICE WINDOW. ESTABLISHMENT DOES ONLY SAME-DAY SERVICE. ENSURE COMINGLED ITEMS DO NOT EXCEED THE SAME-DAY SERVICE WINDOW.
Comply By: 8/11/2025 Originally Issued On: 8/11/2025

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT: 3-COMPARTMENT SINK USED FOR HANDWASHING. DESIGNATE HANDWASHING SINK AND USE FOR HANDWASHING ONLY.
Comply By: 8/11/2025 Originally Issued On: 8/11/2025

Food & Beverage General Comment

INSPECTION CONDUCTED WITH CLARA CAMPBELL, HOUSING MANAGER, AND CASEY HAMANN, LALD FOR THIS FACILITY AND 4 OTHERS. FOOD AND BEVERAGE INSPECTION CONDUCTED AS PART OF AN HRD NURSING SURVEY. 2 NSF 184 DISHWASHERS USED TO SANITIZE. PREVIOUSLY RAN THERMAL STICKERS VERIFIED SANITIZING TEMPERATURES OF AT LEAST 180F IN BOTH DISHWASHERS.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1029251097 from 8/11/2025

Trevor McCliment

CLARA CAMPBELL
HOUSING MANAGER

Trevor McCliment,
Public Health Sanitarian 3
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trevor.mccliment@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

CHERRYWOOD ANDOVER
Andover
County/Group: Anoka County

Inspection Info

Report Number: F1029251097
Inspection Type: Full
Date: 8/11/2025
Time: 1:30:27 PM

New Record: **Product/Item/Unit:** YOGURT; **Temperature Process:** COLD HOLDING
Location: 150 MAIN COOLER at 48 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** BUTTER; **Temperature Process:** COLD HOLDING
Location: 150 MAIN COOLER at 43 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** BUTTER; **Temperature Process:** COLD HOLDING
Location: 150 MAIN COOLER at 44 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** SLICED TURKEY; **Temperature Process:** COLD HOLDING
Location: 150 MAIN COOLER at 48 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** DELI MEAT; **Temperature Process:** COLD HOLDING
Location: 140 MAIN COOLER at 37 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** MILK; **Temperature Process:** COOLING
Location: 140 2ND COOLER at 42 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** MILK ; **Temperature Process:** COLD HOLDING
Location: 140 2ND COOLER at 39 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** CREAM CHEESE; **Temperature Process:** COOLING
Location: 150 STORAGE ROOM COOLER at 42 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** BUTTER; **Temperature Process:** COLD HOLDING
Location: 150 STORAGE ROOM COOLER at 39 Degrees F.
Comment:
Violation Issued?: No

<u>New Record</u>: Product/Item/Unit: SLICED TURKEY**; Temperature Process:** COLD HOLDING
Location: 150 MAIN COOLER at 47 Degrees F.
Comment:
Violation Issued?: No

<u>New Record</u>: Product/Item/Unit: MILK**; Temperature Process:** COLD HOLDING
Location: 150 2ND COOLER at 38 Degrees F.
Comment:
Violation Issued?: No